WELCOME!

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

Please fill out this form completely. The better we communicate, the better we can care for you.

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____

Nickname: _____ ❑ Male ❑ Female

Child's Birthdate: ___/___/___ Child's Age: _____

School: _____ Grade: _____

Child's Home #: (____)_____ **SS #:** _____

Child's Home Address: _____

APT / CONDO #

_____

CITY STATE ZIP

2 Who Is Accompanying The Child Today?

Name: _____

Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No

Whom may we **Thank** for referring you: _____

Other family members seen by us: _____

_____

Previous / Present Dentist: _____

Last visit date: _____

Parent's Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

3

Parent: ❑ Mother ❑ Father ❑ Step Parent ❑ Guardian

Name: _____ Birthdate: ___/___/___

Cell #: (____)_____ Hm #: (____)_____

Employer: _____ Work #: (____)_____

Email: _____ SS #:

Parent: ❑ Father ❑ Mother ❑ Step Parent ❑ Guardian

Name: _____ Birthdate: ___/___/___

Cell #: (____)_____ Hm #: (____)_____

Employer: _____ Work #: (____)_____

Email: _____ SS #: _____

4 Person Responsible For Account

Name: _____ **Relation:** _____

Billing Address: _____

_____

Wk #: (____)_____ **Ext:** ____ **Hm #:** (____)_____

DL #: _____ SS #: _____

Who is responsible for making appointments?

Name: _____

Wk #: (____)_____ **Ext:** ____ **Hm #:** (____)_____

5 Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Orthodontic coverage? ❑ Yes ❑ No

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Orthodontic coverage? ❑ Yes ❑ No

CONTINUED ON BACK

6 Has the child ever had the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Diabetes
Y	N	Allergies to any drugs	Y	N	Handicaps / Disabilities
Y	N	Any Hospital Stays	Y	N	Hearing Impairment
Y	N	Any Operations	Y	N	Heart Murmur
Y	N	Asperger Syndrome	Y	N	Hemophilia
Y	N	Asthma	Y	N	Hepatitis
Y	N	Autism	Y	N	HIV+ / AIDS
Y	N	Cancer	Y	N	Kidney / Liver Problems
Y	N	Congenital Heart Defect	Y	N	Rheumatic / Scarlet Fever
Y	N	Convulsions / Epilepsy	Y	N	Tuberculosis (TB)

Please discuss any medical problems that the child has had:

_____

_____

_____

7 Why did you bring the child to the dentist today?

_____

_____

Has the child ever had a serious / difficult problem associated with previous dental work? ❑ Yes ❑ No

Is the child's water fluoridated? ❑ Yes ❑ No

Is the child taking fluoridated supplements? ❑ Yes ❑ No

Has your child ever been prescribed Fosamax or any other bisphosphonate? ❑ Yes ❑ No

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Does the child brush his / her teeth daily? ❑ Yes ❑ No

Floss his / her teeth daily? ❑ Yes ❑ No

Child's Physician: _____

Phone #: _____ Last Visit Date: _____

Is the child currently under the care of a physician? ❑ Yes ❑ No

Describe the child's current health: ❑ Good ❑ Fair ❑ Poor

Please list all drugs that the child is currently taking:

_____

_____

_____

Please list all drugs/materials that the child is allergic to:

_____

8 Does the child have the following habits?

Y	N	**Lip Sucking / Biting**
Y	N	**Nail Biting**
Y	N	**Nursing Bottle Habits**
Y	N	**Thumb / Finger Sucking**

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

9

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of parent or guardian **Date**

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.

Initials: _____ **Date:** _____

Doctor's Comments: _____

_____

_____

_____

_____

_____

Medical History Update

1. Date: _____ Signature: _____

Comments: _____

_____

2. Date: _____ Signature: _____

Comments: _____

_____

3. Date: _____ Signature: _____

Comments: _____

_____